THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-015294
STATE FILE NUMBER

FILED MAY 6 1959 Registration District No. ____ Primary Registration District No. ____ Registrar's No. 3853

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN St. Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis State — Length of stay in lb 29 years	d. STREET ADDRESS (If outside, give location) 4222 Humphrey — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: Emil	Middle	Last: Langkopf	4. DATE OF DEATH Month: April	Day: 17,	Year: 1959
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]	8. DATE OF BIRTH: 1892	9. AGE (In years last birthday): 67	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk	10b. KIND OF BUSINESS OR INDUSTRY: Railroad	11. BIRTHPLACE (City and state or country): St. Louis Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME: ----- Langkopf	13b. MOTHER'S MAIDEN NAME: unknown	14. NAME OF HUSBAND OR WIFE: none			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unknown (If yes, give war or dates of service): -----	16. SOCIAL SECURITY NO.: unknown	17. INFORMANT Address: Mrs. Carl Schonig-Homewood, Illinois			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary thrombosis	Few min.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)		
DUE TO (c)	420.1	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from June 7, 1929, to April 17, 1959 and last saw her/him alive on April 17, 1959
Death occurred at 5:10 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John H. McMahon M.D.	22b. ADDRESS: 5400 Arsenal St.	22c. DATE SIGNED: 4/18/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal	23b. DATE: Apr. 20, 1959	23c. NAME OF CEMETERY OR CREMATORY: St. Trinity Lutheran Ceme.	23d. LOCATION (City, town, or county): St. Louis Co.,	(State): Missouri
24. FUNERAL DIRECTOR: WACKER-HELDERLE U & L. CO.	ADDRESS: 3634 Gravois Ave.	25. DATE RECD. BY LOCAL REG.: APR 20 '59	26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ——————, Student Embalmer No. ——————

working under my personal supervision.

Student ——————
Signature of Student Embalmer

Signed Felix J. Krieger

Licensed Embalmer No. 3497

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.